SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark Leno

Senator Elaine K. Alquist
Senator John Benoit

April 23, 2009

9:30 a.m. *or*
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
4280	Managed Risk Medical Insurance Board • Healthy Families Program
4440	Department of Mental Health • Healthy Families Program (Supplemental mental health services)
4260	Department of Health Care Services • Medi-Cal Program—selected issues as noted

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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I. Managed Risk Medical Insurance Board (MRMIB)

A. OVERALL BACKGROUND

Purpose and Description of Department. The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers the: **(1)** Healthy Families Program; **(2)** Access for Infants and Mothers (AIM) Program; and **(3)** Major Risk Medical Insurance Program (MRMIP).

Summary of Budget Appropriation. The budget proposes total expenditures of just over $1.3 billion ($406.4 million General Fund) for all programs administered by the Managed Risk Medical Insurance Board for 2009-10 as shown in the chart below.

Summary of Expenditures

(dollars in thousands)	2008-09	2009-10	$ Change
Program Source			
Major Risk Medical Insurance Program (including state support)	$54,858	$39,439	-($15,419)
Access for Infants & Mother (with state support)	$133,695	$150,984	$17,289
Healthy Families Program (with state support)	$1,158,469	$1,130,900	$27,569
County Health Initiative Program	$2,420	$2,413	(-$7)
Totals Expenditures	**$1,349,442**	**$1,323,736**	**-($25,706)**
General Fund	$399,916	$406,352	$6,436
Federal Funds	$808,470	$801,579	-($6,891)
Other Funds	$141,056	$115,805	-($25,251)

(Discussion items for the Healthy Families Program begin in the next page.)

1. Healthy Families Program—Discussion of Existing Budget

Background—Funding for the Healthy Families Program (HFP). The Healthy Families Program (HFP) is California's version of the federal State's Children's Health Insurance Program (CHIP) and was implemented in 1997-98. California receives a 66 percent federal match for each state dollar provided. It should be noted that federal CHIP funding is an *"allotment",* and as such, this program is *not* an entitlement. In addition to the federal allotment and State General Fund support, premium payments received from families for the enrollment of their children (i.e., subscribers) are used to offset expenditures.

On February 4, 2009, President Barack Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA was designed to "reauthorize" the financing of children's health insurance (Healthy Families in California) for the next 4.5 years (April 1, 2009 to September 30, 2013), as well as to make several other changes to the program. Due to timing, CHIPRA changes are *not reflected* in California's February budget package. The Administration will be bringing forth proposed changes at the May Revision to address these issues. (Further, a discussion of *budget-related* CHIPRA issues is included later in this Agenda.)

Summary of Budget Appropriation. The February budget agreement provides an appropriation of $1.121 billion ($403.9 million General Fund, $710.2 million Federal Title XXI Funds, $904,000 Proposition 99 Funds, and $6.5 million in reimbursements) for the HFP, excluding state administration.

This reflects a *net reduction* of $27.6 million (total funds), or a 2 percent reduction as compared with the revised current-year. Most of this difference is attributable to implementation of the various cost-containment actions taken in the Budget Act of 2008. Therefore, the revised current-year reflects only 4 months of savings whereas 2009-10, captures a full-year of savings. In addition, HFP caseload is estimated to increase by 3 percent, as discussed further below. No other significant changes are proposed.

Each of the previously enacted cost-containment issues and its estimated reduction amount is shown in Table #1, below. It should be noted that a total reduction of over $160 million ($57 million General Fund) is to be achieved over the two-year period.

Table #1: Summary of Enacted Reductions for Healthy Families Program

Description of Actions Taken in 2008	2008-09 Reduction Amount	2009-10 Reduction Amount	Two-Year Total Reduction
1. Increase premiums by an average of $1 per month per member**	$10.7 million ($2.9 million GF)	$62.5 million ($23.2 million GF)	$73.2 million ($26.1 million GF)
2. Reduce plan rates by 5 percent	$24.8 million ($8.8 million GF)	$57.1 million ($20.2 million GF)	$81.9 million ($29 million GF)
3. Annual benefit limit for dental coverage	--	$5.3 million ($1.9 million GF)	$5.3 million ($1.9 million GF)
Totals	$35.5 million ($11.7 million GF)	$124.9 million ($45.3 million)	$160.4 million ($57 million GF)

** Premium amounts vary by income level, family size and by type of plan.

Description of Change in the Premium (See #1, in above Table). Effective February 1, 2009, the MRMIB is applying the premium adjustments as described below. This application is consistent with the Legislature's direction provided in the Budget Act of 2008. The savings in Table #1, above, assume an enrollment reduction of almost 8,000 children in the current-year and about 44,000 children in 2009-10, as well as increased premium collections.

- There are no changes for families with incomes from 100 to 150 percent of poverty. Due to federal cost-sharing requirements, premiums cannot be raised. The premium is $7 per child with a maximum per family of $14 per month. If the "community provider" plan is chosen the premium is $4 per child with a maximum per family of $8. About 31 percent of the HFP scribers are in this income bracket.
- Families with incomes from 150 percent to 200 percent will have their premiums increased from $9 per child per month to $12 per child per month (i.e., $3 more per month). The family maximum amount for these subscribers will be adjusted from $27 per month to $36 per month. About 40 percent of the HFP scribers are in this income bracket.
- Families with incomes over 200 percent will have their premiums increased from $17 per child to $19 per child per month (i.e., $2 more per month). The family maximum amount for these subscribers will be adjusted from $45 per month to $51 per month. About 29 percent of the HFP subscribers are in this income bracket.

HFP does offer subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include (1) $3 per child per month discount for enrollment in a "community provider plan"; (2) subscriber paying 3 months in advance to get one month "free"; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer.

Description of HFP Plan Rate Reduction (See #2, in above Table). Effective February 1, 2009, MRMIB has negotiated and implemented an overall 5 percent rate reduction for plans participating in the HFP. Due to this negotiation, *81,000 children* needed to change plans since some plans dropped HFP coverage in certain geographic regions because of the rate reduction. Of these children: (1) 82 percent were shifted from Anthem Blue Cross coverage to other plans; (2) 10 percent were shifted from Health Net; and (3) 8 percent were shifted from Blue Shield to other plans.

Description of Dental Benefit Limit (See #3, in above Table). Effective July 1, 2009, MRMIB will proceed with the annual benefit limit of $1,500 for dental coverage as directed from actions taken in the Budget Act of 2008.

MRMIB estimates that about 5 percent of the HFP enrolled children *may* hit this limit in 2009-10. In addition, since this proposal reduces total benefits to subscribers it also reduces dental plan costs, thereby allowing for a reduction in the rates paid to these plans.

Budget Year Caseload Adjustments. *In addition*, the budget reflects HFP caseload increases. Specifically, it assumes enrollment of 941,786 children as of June 30, 2009, an increase of 36,200 children, or a growth rate of about 3 percent, over the revised current year enrollment.

This estimated HFP enrollment of children for 2009-10 is summarized by population segment below:

- Children in families up to 200 percent of poverty 701,496 children
- Children in families between 201 to 250 percent of poverty 240,276 children
- Children in families who are legal immigrants 17,592 children
- Access for Infants and Mothers (AIM)-Linked Infants 18,698 children
- New children due to changes in Certified Application Assistance 9,008 children
- Bottom-line adjustment attributable to enactment of reductions (-45,284) children

Overall Background—Description of the Healthy Families Program. The HFP provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

Table #2: Background Summary of Existing Eligibility for the Healthy Families Program

Type of Enrollee in the HFP	Income Level Based on Federal Poverty	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers.	200 % to 300 %	• Income from 200% to 250%, covered through age 18. • Income is above 250 %, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers from 133 percent and above because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100 %. Families with two children may be "split" between programs due to age.
Some children enrolled in County "Healthy Kids" programs. These include (1) children without residency documentation; and (2) children from 250 percent to 300 percent of poverty.	Not eligible for Healthy Families Program, including 250 percent to 300 percent	State provides federal S-CHIP funds to county projects as approved by the *MRMIB.* Counties provide the match for the federal funds.

Background—HFP Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the State's Children's Health Insurance Program (S-CHIP)—required states to use this "benchmark" approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has *historically* always been available.

In addition to these HFP benefits, enrolled children can also access the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute that created California's Healthy Families Program (i.e., California's S-CHIP). These services are also available to children enrolled in Medi-Cal.

Subcommittee Staff Comment and Recommendation. As discussed, the HFP is now implementing the reductions contained in the Budget Act of 2008. These adjustments will be updated at the May Revision, along with a revised caseload estimate for the current-year and budget-year.

It is important to hear from the MRMIB regarding its implementation of the reductions and to obtain preliminary information as to their potential affect on the program.

Questions. The Subcommittee has requested the Managed Risk Medical Insurance Board to respond to the following questions:

1. **MRMIB**, Please provide a *brief* summary regarding the implementation of the three reductions—i.e., the increase in premiums, negotiation of revised contract rates, and the capitation of dental services.
2. **MRMIB**, How has enrollment into the HFP been affected by these changes thus far, including the 81,000 children who had to shift plans due to the health plan rate reduction?
3. **MRMIB,** Please provide a *brief* summary of the existing budget and highlight *key* changes that have not already been referenced.

2. Reauthorization of CHIP Provides for: (A) Reauthorized Federal Allotment, (B) Covers Legal Immigrant Children, (C) Requires Citizenship Documentation & (D) Selected Other Issues

Background—Reauthorization of CHIP. The federal Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009, signed by President Barack Obama in February, is sweeping legislation. *First*, it was designed to "reauthorize" the financing of children's health insurance (Healthy Families in California) for the next 4.5 years (April 1, 2009 to September 30, 2013) and is financed largely by a $0.62 increase in the federal tax on cigarettes.

Second, it makes several other changes to the program by offering states additional children's coverage options, as well as requiring certain other programmatic changes to improve quality assurance measures, data collection and other components of the program. Some of these federal CHIPRA changes will be addressed through California's budget process as needed. Other issues will require state policy discussions over the next year or so as components of the federal legislation are clarified by MRMIB working with the federal CMS, as well as with involved stakeholders and the Legislature.

Third, it interacts with California's Medi-Cal Program in several areas. These issues will be discussed under the Department of Health Care Services, later in this Agenda.

Budget Discussion Issues. Due to timing, California's February 2009 budget package does *not reflect changes* contained within the federal CHIPRA. The MRMIB states that some CHIPRA issues will be forthcoming at the Governor's May Revision, to be received by the Legislature in late May. It is anticipated that fiscal changes, as well as trailer bill language proposals will be forthcoming.

However, it is important for the Subcommittee to discuss and clarify key aspects of the federal CHIPRA that pertain to California's budget *prior* to the May Revision. These issues are as follows:

- A. California's Federal CHIP Allotment. CHIPRA increases the federal allotment available to states and uses a three-part formula for states to determine their federal allotment amount. It also establishes a mechanism for "rebasing" state allotments every two years to ensure that federal funds are targeted to states that are using them, or the funds will be re-distributed.

  Based on an *initial* calculation, the MRMIB anticipates California to receive a federal allotment of $1.481 billion for federal fiscal year 2009 (October 1, 2008 to June 30, 2009). These federal Title XXI Funds (as the federal allotment is called) require a 35 percent General Fund match, *as needed*, to operate Healthy Families, as well as certain components within the Medi-Cal for Children Program.

According to the MRMIB and an independent consultant, this allotment of federal Title XXI Funds for California should be sufficient for the state to operate the Healthy Families Program without any concern of a federal funding shortfall.

Any unexpended federal Title XXI Funds can roll forward to the next federal fiscal year (two-years to expend). The law also outlines a system for redistributing unexpended federal funds to states facing any federal CHIP shortfall in future years.

Finally, it should be noted that CHIPRA allows States to expand eligibility or benefits under CHIP beyond the federal funding methodology contained in the law. States can request these expansions only in federal fiscal years 2010 and 2012. To do so, a State must submit a "State Plan Amendment" to the federal CMS by August 31st preceding the beginning of the applicable fiscal year (e.g., by August 31, 2009 for federal fiscal year 2010).

Therefore, if California desired to expand Healthy Families Program enrollment from 250 percent to 300 percent of poverty, it would need to submit a State Plan Amendment by August 31, 2009. In addition, this would require State statutory changes and increased expenditures of about $58.5 million ($21.1 million General Fund and $37.4 million federal funds) to provide coverage to about 50,000 children who are estimated to be in this aspect of the population and would otherwise be eligible for Healthy Families.

- B. Legal Immigrant Children—California Can Receive Federal Funds in Healthy Families. CHIPRA gives states the *option* of providing coverage for legal immigrant children with less than 5-years in the United States and receiving federal funds for this purpose.

  California law has always offered enrollment in Healthy Families for legal immigrant children with less than 5-years in the U.S. if they otherwise meet all other Healthy Families Program requirements. California has covered these children since inception of the Healthy Families Program using 100 percent General Fund support.

  As such, this CHIPRA *option* would now enable Healthy Families to draw federal funds for this purpose and *save about $12.2 million in General Fund support* based on the 2009-10 February budget package. Presently the HFP expends about $18.8 million (General Fund) on this coverage.

  However, the Administration states this savings estimate will be updated at the May Revision. MRMIB notes that under this CHIPRA *option* some children might have to provide additional documentation at "annual eligibility renewal (AER) to re-verify their documentation status. Presently the HFP requires a copy of documentation of children's legal status upon initial enrollment but no additional documentation at AER. In addition, they contend that implementing these provisions may result in lower program enrollment retention and could result in increased administrative costs.

  (The Medi-Cal Program will be discussed further below in this Agenda under the DHCS Item.)

- C. Citizenship Documentation—Added Requirements. The federal CHIPRA extends existing Medicaid citizenship *and* identity documentation requirements to CHIP (Healthy Families Program) which must be implemented by January 1, 2010.

  According to the MRMIB, about 92 percent of children enrolled in Healthy Families are born in California. Therefore, MRMIB could link to the vital statistics database created by the Department of Health Care Services (DHCS) for Medi-Cal citizenship documentation and could automatically identify children using California's birth certificate records (as maintained by the Department of Public Health).

  In addition, the MRMIB believes the "identity documentation" component of this new requirement can be addressed for most children through a revision to the "joint application" (an application used to enroll children who may be eligible for Medi-Cal or the Healthy Families Program). Specifically, the revised joint application would allow a parent/guardian to attest to the identity of children *less than* 17 years of age. Federal law provides for a parent/guardian's declaration for this age group.

  However, it is not clear how to satisfy the new requirement for 17 and 18 year olds enrolled in Healthy Families. Further, it is unclear what these administrative changes will cost the Healthy Families Program.

  The MRMIB states that changes to the HFP eligibility verification process as outlined above will likely require emergency regulations

  Finally, it should be noted that the Healthy Families Program does not collect Social Security Numbers (SSNs) are part of its enrollment process. The Medi-Cal Program does collect SSN information and is affected by the federal CHIPRA provisions in a different manner.

  (The Medi-Cal Program will be discussed further below in this Agenda under the DHCS Item.)

- D. Selected Other Issues. As noted previously, CHIPRA is sweeping legislation which addresses many aspects of the program. Other issues the Subcommittee should be aware of are as follows:

  - *Requires Dental Coverage*. CHIPRA requires States to include coverage of dental services as part of the benefit package. California has always provided dental coverage within the HFP.

    However, two issues have been raised. First, it is not yet clear if California's orthodontia benefit meets the CHIPRA requirement since the HFP coverage for this is specific dental procedure is limited. Second, CHIPRA requires certain encounter claims-based information for dental coverage and California does not presently collect this information; therefore, changes may be required.

    The MRMIB will provide an update on these issues at the May Revision.

- *Increased FMAP for Translation Services.* CHIPRA provides an enhanced federal matching rate (i.e., 75 percent) for translation and interpretation services in connection with enrollment of, retention of, and use of services for families whose primary language is not English. The MRMIB is presently assessing the cost-effectiveness of separating out these services from the Administrative Vendor contract and the Health Plan contracts where these services are presently provided and funded.

  The MRMIB states that more information should be available at the May Revision regarding this issue.

- *Additional Funds for Outreach & Enrollment "Grants".* CHIPRA provides $100 million for federal fiscal years 2009 to 2013 for outreach and enrollment "grants" designed to increase enrollment in CHIP (Healthy Families) and Medicaid (Medi-Cal). Of this amount, 10 percent is available to American Indian Reservations.

  MRMIB states that more information should be forthcoming from the federal CMS regarding these grants but noted that these funds can go to States, local governments and other organizations.

- *Prenatal Care for Pregnant Women—Unborn Option.* CHIPRA explicitly leaves intact an existing "unborn child" regulation whereby states can obtain federal CHIP funds for prenatal care provided to pregnant women. California presently has a federal Waiver for this purpose which enabled the state to save almost $200 million General Fund in the Budget Act of 2005 and forward (i.e., savings in the Access to Infants and Mothers Program and the Medi-Cal Program).

  The MRMIB states *no adjustments are necessary* to continue this existing approach.

Subcommittee Comment and Recommendation. The federal CHIPRA is sweeping legislation which provides California with an opportunity to obtain increased federal funding and continue the success of our Healthy Families Program, and Medi-Cal for Children Program. Due to the State's fiscal situation, the Subcommittee will need to focus its efforts on those CHIPRA changes which need to be in effect during the State's 2009-2010 fiscal year. At this time, it is recommended to have the MRMIB respond to questions and to leave these issues open until receipt of the May Revision (in late May).

Questions. The Subcommittee has requested the MRMIB to respond to the following questions:

1. **MRMIB**, Please discuss each issue as noted above (commencing with "A") and provide a brief summary and comment regarding the issue, including the potential need for budget action to be taken in 2009-10.

II. Department of Mental Health

1. Healthy Families Program—Supplemental Mental Health Services

Background—Healthy Families Program & Supplemental Mental Health Services. The Healthy Families Program (HFP), as discussed above under the Managed Risk Medical Insurance Board (MRMIB), provides health care coverage and dental and vision services to children as specified.

The enabling state statute for the HFP also provides *"supplemental" mental health* services to children referred by health plans participating in the HFP who have been diagnosed as being seriously emotionally disturbed (SED). Specifically, medically necessary mental health services for HFP enrollees with SED that go *beyond* the basic mental health services provided by participating health plans are the responsibility of County Mental Health Plans.

The Department of Mental Health (DMH) is responsible for budget appropriations for the HFP supplemental mental health services provided by County Mental Health Plans.

The supplemental mental health services provided to children enrolled in the HFP who are SED can be billed by County Mental Health Plans to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available. The supplemental mental health services

Summary of Budget Appropriation. The February budget package reflects total expenditures of $49.2 million, including county administration expenditures, for 2009-10. This reflects an increase of $7.3 million (increase of $235,000 General Fund and $7.1 million in Reimbursements) as compared to the current-year.

Of the total amount, $44.7 million (total funds) is for local assistance and $4.5 million, or 10 percent, is for county administration costs. The DMH states that this estimate is based on current expenditures of approved claims as monitored by the DMH. Counties are responsible to provide a contributing 35 percent match to the program overall. Federal CHIP funds provide a 65 percent match, except for certain populations.

With respect to legal immigrant children residing in the U.S. for less than five years, the DMH presently provides a 65 percent General Fund match to the counties 35 percent match since federal CHIP funds were not previously available for this purpose until the CHIPRA changes.

Budget Discussion Issues. There are two key issues with this appropriation.

First, the federal CHIPRA will now provide federal funding at the 65 percent level for legal immigrant children residing in the U.S. for less than five years. As such, a May Revision adjustment will be forthcoming from the Administration to reflect this change. Since the state presently provides a 65 percent match for this population in lieu of federal fund support, a small amount of General Fund savings will be achievable.

Second, the MRMIB has just completed an analysis of these supplemental mental health services which was released on April 22nd. Key findings include the following:

- Very few children in the HFP receive services for treatment of mental health conditions from either County Mental Health Plans or from HFP participating health plans.
- The percentage of seriously emotionally disturbed children referrals accepted by counties has been declining. In 2006-07, sixty-three percent of HFP children referred for services were accepted by County Mental Health Plans as compared to 72 percent in 2004-05.
- The average cost per case increased 75 percent from $2,615 in 2000 to $3,488 in 2007, which is far greater than the average 4.3 percent annual increase in the medical consumer price index during these years.

Subcommittee Comment and Recommendation. First, the DMH will be providing updated expenditures and federal funding adjustments due to CHIPRA at the May Revision. This issue should be relatively straightforward at that time.

However, the issues raised in the MRMIB report released on April 22 require further deliberation. It is therefore recommended to direct the MRMIB and DMH to report back to the Subcommittee prior to the May Revision regarding potential follow-up.

Questions. The Subcommittee has requested the DMH and MRMIB to respond to the following questions:

1. **DMH**, Please provide a *brief* summary of the budget request.
2. **DMH,** Roughly, what amount of General Fund savings is likely to be achieved from the federal CHIPRA change for legal immigrants residing in the U.S. for less than five years?
3. **MRMIB**, Please provide a brief summary of the recent findings regarding the provision of mental health services under the HFP. What follow-up is being contemplated at this time?

III. Department of Health Care Services: Medi-Cal Program

A. OVERALL BACKGROUND

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. *Generally*, California receives a 50 percent match from the federal government for most Medi-Cal Program expenditures. This federal match will increase to 61.59 percent under the federal American Recovery & Reinvestment Act, as discussed below, for a 27-month period.

Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents; (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and (3) a wrap-around coverage for low-income Medicare recipients.

Who is Eligible and Summary of Medi-Cal Enrollment: Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: **(1)** aged, blind or disabled; **(2)** low-income families with children; **(3)** children only; and **(4)** pregnant women.

Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of pocket expenditures or combinations of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state's option.

The Medi-Cal Program also has several "special programs" that provide limited services for certain populations**.** These include the **(1)** Emergency Medical Services Program which provides emergency medical services to undocumented individuals; **(2)** the Family PACT Program which provides reproductive health care services; **(3)** the Breast and Cervical Cancer Program which provides services related to cancer for women up to 200 percent of poverty; **(4)** the Disabled Working Program which allows certain disabled working individuals to pay a premium to buy into the Medi-Cal Program; and **(5)** the Tuberculosis Program which provides treatment for TB. These programs are limited in their eligibility and in the services that are funded under them.

Estimated Medi-Cal enrollment for 2009-10 is about 7 million people. Medi-Cal provides health insurance coverage to about 18 percent of Californians. The projected Medi-Cal eligible caseload is summarized in the table below.

Summary of Caseload Medi-Cal Eligibles	2009-10 Estimate Eligibles
Families/Children	
CalWORKS	1,392,100
Working Families (1931 b Program)	3,006,935
Pregnant Women	43,700
Children (100 % and 133% programs)	277,945
Aged/Disabled	
Aged	699,914
Blind	23,800
Disabled	1,096,573
Medically Indigent	227,842
Other Various Categories	179,500
Undocumented Persons	68,600
TOTALS	**7,016,909**

Summary of Budget Appropriation*:* The budget proposes total expenditures of $40.5 billion ($15.4 billion General Fund, $24.3 billion federal Title XIX Medicaid funds, and $862.5 million in other state funds) for local assistance the Medi-Cal Program in 2009-10.

This reflects a *net* General Fund increase of $969.8 million, or an increase of about 6.6 percent above the revised current-year level as shown in the chart below.

Medi-Cal Funding Summary *(Dollars in Thousands)*	2008-09 Revised	2009-10 Budget	Difference	Percent
Local Assistance				
Benefits	$35,911,954	$37,335,221	$1,423,267	3.9%
County Administration (Eligibility)	$2,825,667	$2,901,702	$76,035	2.7%
Fiscal Intermediaries (Claims Processing)	$310,303	$295,136	(-$15,167)	(-4.9%)
Total Local Assistance	**$39,047,924**	**$40,532,059**	**$1,484,135**	**3.8%**
General Fund	$14,413,726	$15,369,562	$955,836	6.6%
Federal Funds	$23,785,630	$24,300,006	$514,376	2.2%
Other State Funds	$848,568	$862,491	$13,923	1.6%

The February budget package reflects the following *key* adjustments to the Medi-Cal Program for 2009-10 as shown below.

- *Restores Governor's Proposed Medi-Cal Eligibility Reductions.* The Legislature rejected all of the Governor's proposals to reduce Medi-Cal eligibility and restored $485 million in General Fund support for this purpose.

- *Deletes Funding for Medi-Cal Optional Benefits*. As proposed by the Governor, certain Medi-Cal Optional Benefits were not funded in the February budget package, nor was the trigger activated as specified to restore these services, including Adult Dental, Optical Labs, Optometrists/Opticians, Chiropractor, Psychologist services, Podiatrist, Acupuncturist, Audiologist and Incontinence Creams and Washes. This action reduced Medi-Cal by about $129 million in General Fund support. As has been previously discussed in the Subcommittee, elimination of these benefits is an extremely difficult action.

  The DHCS states they have accounted for potential cost-shifts to other services, such as emergency room usage; however, no one knows the potential consequences to enrollees or the health care safety net since this has never previously occurred. However, an increase of $8.2 million (General Fund) will be needed in the Department of Developmental Services to continue to provide these services through the Regional Center system. This will be discussed at a later date.

- *Redirects A Portion of the Safety Net Care Pool Funds*. As proposed by the Governor, a 10 percent reduction, or $54 million General Fund, was redirected from Public Hospitals to backfill for General Fund support in certain health care programs for 2009-10.

- *Suspends Cost Adjustment for Medi-Cal County*. As proposed by the Governor, the cost-of-doing business adjustment to support Medi-Cal eligibility processing conducted by counties, as a surrogate for the state, was not provided. This resulted in a reduction of $24.7 million in General Fund support for 2009-10.

- *Continues the Implementation Delay of Senate Bill 437 (Escutia), Statutes of 2006.* Among other things, this statute authorizes a pilot program in two counties to evaluate "self-certification" of income and assets by Medi-Cal applicants and Medi-Cal enrollees. The Governor vetoed funding for implementation in 2007, and implementation has been delayed since this time. The February budget package does not include funding for implementation.

(Discussion issues for this Subcommittee hearing begin on the next page.)

1. Implementation of SB 3X 24 (Alquist) and Receipt of Federal ARRA Funds

Background—Significant Increase to Federal Medical Assistance Percentage (FMAP). Among many things, Title V of the American Recovery and Reinvestment Act of 2009 (ARRA) increases the federal share of the Medicaid Program for states. The DHCS estimates California will receive an increase in our FMAP of 11.59 percent which would provide for a *61.59 percent* FMAP for California's Medi-Cal Program from October 1, 2008 through December 2010.

As shown in Table #1 below, this enhanced FMAP would provide California with an estimated $10.112 billion in *additional* federal funds for the 27-month period. These additional federal funds result in savings to the State of California, as well as to local governmental entities including counties. This is because federal Medicaid funds are used to support various health and human services programs operated by both the state and local governments where applicable.

The estimated combined State General Fund savings for 2008-09 and 2009-10 is $6.581 billion from the enhanced FMAP (i.e., $2.766 billion plus $3.817 billion). Due to the state's existing fiscal condition, it is critical for the DHCS to fully and quickly claim these enhanced federal funds, particularly for Medi-Cal services that have already been billed (i.e., from October 1, 2008 forward).

Table #1—DHCS Summary of Estimated Federal Funds from Increased FMAP (11.59%)

Area	State Fiscal Year 2008-09	State Fiscal Year 2009-10	State Fiscal Year 2010-11	Total Federal Funds
Estimate of Federal Funds for CA at Additional 11.59 percent	$3,269249,000	$4,561,824,000	$2,280,912,000	$10,111,985,000
GF Cost of SB 24 X3 (Alquist)	($9,322,500)	($91,902,000)	($91,902,000)	($193,126,500)
Total Net Savings from FMAP	**$3,259,926,000**	**$4,469,922,000**	**$2,189.010,000**	**$9,918,858,000**
Net Savings by Fund Source:				
State General Fund Savings	*$2,763,585,000*	*$3,817,405,000*	*$1,862,751,500*	*$8,443,741,500*
Other State Special Fund Savings	$4,346,000	$3,477,000	$1,738,500	$9,562,000
County/Local Savings	$491,995,500	$649,040,000	$324,520,000	$1,465,555,500
State General Fund Savings Split				
DHCS Operated Programs	$1,999,645,000	$2,821,824,000	$1,364,961,000	$6,185,430,000
Other State Department Programs	$764,940,000	$995,581,000	$497,790,500	$2,258,311,500

Most of the General Fund savings will accrue to the Medi-Cal Program administered by the DHCS. However other state departments-- most notably the Department of Mental Health (DMH), Department of Developmental Services (DDS), and Department of Social Services (DSS)—will also achieve savings from this additional federal support as reflected collectively in the Table above (i.e., "Other State Department Programs").

It should be noted that the 11.59 percent increase in federal FMAP is a *separate* federal match and needs to be tracked separately by the DHCS for reporting purposes to the federal CMS for accountability purposes.

Background—Medi-Cal Federal Claiming is Complex *and* ARRA Has Requirements.
Several departments administer complex "Waiver" programs for special populations, such as individuals with mental illness, individuals with developmental disabilities, and individuals utilizing In-Home Supportive Services. These various Waiver programs access federal Medicaid funds and have various payment arrangements.

For example, the DMH contracts with County Mental Health Plans to provide Medi-Cal mental health services, including Mental Health Managed Care and the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. Various mental health providers also bill independently for these services. As discussed in the Subcommittee's March 26th hearing, the federal CMS has *released two audits* regarding significant concerns with the DMH billing practices and has *two additional audits* regarding the DMH which are forthcoming.

In order for the DHCS to obtain the retroactive 11.59 percent increase in FMAP (i.e., from October 1, 2008 forward) for other departments, including Waiver programs, the other departments need to submit revised invoices to the DHCS claiming the additional federal fund amounts. The DHCS states it has provided instructions to other departments for this purpose and revised invoices are being processed. To-date, over $1.7 billion in increased federal FMAP has been drawn by the DHCS.

The DHCS will need to assertively administer the program to meet the AARA requirements, *and* any additional federal CMS requirements that may come forth. The federal CMS will be tracking State's expenditures, as well as compliance with the provisions of the federal ARRA. As such, federal CMS audit exceptions could occur if the DHCS is not vigilant.

The ARRA specifies the following additional requirements for States to receive the enhanced federal funds:

- *1. No Eligibility Decreases or New Enrollment Hurdles*. States must maintain Medi-Cal eligibility levels at least at the same level as provided as of July 2008 and may not impose new procedural hurdles in enrollment. Any State out of compliance with this requirement has until July 1, 2009 to rescind the action. The State would then be *fully* eligible for the enhanced match, retroactive to October 1, 2008.

  However, any state that implements more restrictive policies as of July 1, 2008, and rescinds such policies *after* July 1, 2009, will *only* be eligible for the enhanced FMAP beginning with the first calendar quarter that it restored the eligibility policies. Therefore, any state in this situation would sacrifice their enhanced FMAP dollars for all of the preceding period—i.e., from October 1, 2008 until the policy was changed as referenced.

- *2. No Payment Delays—"Prompt Payment"*. States must comply with current rules to promptly pay provider Medi-Cal claims and must apply prompt payment rules to hospitals and nursing homes as well.

Federal prompt payment rules specify that states must pay 90 percent of "clean" claims within 30-days of receipt and 99 percent of "clean" claims within 90-days of receipt. This federal rule applies to provider, hospital, and nursing home Medi-Cal claims dated after the enactment of the ARRA. States are given until *June 1, 2009* to comply with these new prompt payment requirements.

- *3. No Increases in Local Financial Responsibilities*. States cannot increase localities' (such as counties) required shares of Medicaid (Medi-Cal) contributions above the levels in place as of September 30, 2008.

- *4. No Stockpiling of Federal Medicaid Funds*. States may not redirect the increased federal funds into any state reserves or rainy day funds.

To-date the Administration has contended that only one state statutory change was necessary to meet the federal ARRA requirements to obtain the additional FMAP. As discussed in our March 18th Subcommittee hearing, Senate Bill 24 X3 (Alquist), Statutes of 2009, made changes to Medi-Cal eligibility reporting by restoring "annual" eligibility for the enhanced federal fund period. This legislation was enacted to comply with the federal ARRA requirement as noted above. It is estimated that 191,488 children will remain eligible for Medi-Cal in 2009-10 due to this change.

In this hearing the DHCS committed to working with advocacy groups and other interested parties to ensure that Senate Bill 24 X3 (Alquist) is appropriately implemented and that County Welfare Departments, who conduct eligibility processing as a surrogate for the state, are fully informed of the changes.

However, due to reductions attributable to Section 99030 of the Government Code and Section 8.30 of the Budget Act of 2009 (i.e., trigger mechanism was not pulled), concerns have been expressed by constituency groups as to whether *all* of the ARRA requirements will be met as of July 1, 2009.

In addition, the DHCS as the lead State agency for Medi-Cal is obtaining additional direction from the federal CMS as the federal ARRA funds are accessed. Therefore, clarification from the DHCS is needed in order for any necessary changes to be remedied quickly.

Budget Discussion Issues. Due to timing, the February budget package does *not* reflect the enhanced FMAP of 61.59 percent as contained in the ARRA. The Administration states that changes to reflect this calculation will be in the Governor's May Revision to be received by the Legislature in late May. Based on the current DHCS estimate, a total of $6.581 billion in enhanced federal funds should be available for the two state fiscal years (2008-09 and 2009-10) which can be used to offset State General Fund support.

However, there are several *key* aspects regarding the receipt of these enhanced federal funds which need to be clarified *prior* to the May Revision discussion.

These *key* aspects include the following:

- Does California meet *all* ARRA requirements, as noted above, or are additional state statutory changes necessary?
- Specifically, how will the DHCS monitor and track claims for the enhanced federal funds from October 1, 2008 to June 30, 2009 for *all* of the programs it administers, as well as all of the various Waiver programs operated by other state departments?
- How will the federal CMS be providing states with additional direction and how will the DHCS keep the Legislature informed of these federal CMS directives?

Subcommittee Staff Comment and Recommendation. The DHCS should clarify for the Subcommittee key questions regarding the receipt of the federal ARRA funds as noted. It is recommended to keep this issue "open" pending receipt of the Governor's May Revision.

Further, it is recommended to adopt uncodified placeholder trailer bill language as follows to assist in maintaining Legislative oversight of these crucial federal funds:

> "The Department of Health Care Services (DHCS) shall provide the Legislature with a quarterly update, including key fiscal data provided to the federal Centers for Medicare and Medicaid, regarding the implementation of the federal ARRA as it pertains to California's Medi-Cal Program, including all Waiver programs. This quarterly update shall be provided to the fiscal and policy committees of the Legislature within 14 working days of the close of the quarter, commencing as of July 1, 2009. The first quarterly update to be received by the Legislature in July, 2009, shall reflect key issues and fiscal data as it pertains to the federal ARRA retroactive claiming (from October 1, 2008 to June 30, 2009)."

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Are *any* additional state statutory changes necessary in order to meet the federal ARRA requirements? If so, please be specific as to what is needed.
2. **DHCS,** How will the DHCS be monitoring and tracking Medi-Cal claims for these additional federal funds with respect to retroactive claiming (from October 1, 2008) as well as federal claiming for July 1, 2009 going forward?
3. **DHCS**, How will the Administration keep the Legislature informed of any additional federal CMS requirements or other key implementation issues regarding the federal ARRA?

2. Implementation of Federal CHIPRA in the Medi-Cal Program—Legal Immigrant Children and Pregnant Women

Background—Federal Funds Available for Medi-Cal Via CHIPRA. Though the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) primarily affects California's Healthy Families Program, it also contains provisions which interact with the Medi-Cal for Children Program.

CHIPRA enables states to obtain federal matching funds through Medicaid *and* CHIP financing for legal immigrant children and pregnant women during their first five years in the United States. Previously, the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 barred states from receiving federal assistance for this population.

California law has always provided legal immigrants (adults, children and pregnant women) with less than 5-years in the U.S. with *"full-scope"* Medi-Cal services if they otherwise meet all other Medi-Cal eligibility requirements. California has *primarily* used 100 percent General Fund support for this purpose due to the 1996 federal bar. However, when applicable, the DHCS has obtained federal Medicaid funding at a 50 percent match due to federal law regarding *"emergency services".* In addition, as noted under the MRMIB, California is also claiming federal CHIP funds for certain prenatal care as well.

Federal law requires states to provide emergency services (with federal financial participation) to immigrants who meet all other Medi-Cal eligibility requirements regardless of immigration status. *"Restricted-scope"* Medi-Cal includes "emergency services", prenatal care, 60-days of post-partum coverage, and on a very limited basis long-term care.

The DHCS states they are presently claiming a 50 percent federal match for pregnancy services (i.e., emergency services) for these legal immigrant individuals. Further, they are able to claim about 22 percent of the total costs as federal funds for the legal immigrant children's component due to emergency services claiming. The CHIPRA change will enable California to claim an even higher proportion of federal support.

California will be able to claim federal funds for the following populations using both Medicaid (through the ARRA) and CHIP (through the CHIPRA) financing. *Generally*, the type of federal financing available depends on the child's Medi-Cal aid code.

- A 65 percent federal matching rate for legal immigrant children (under 19 years), residing in the U.S. for less than 5-years, who are enrolled in Medi-Cal and eligible for CHIP funding (i.e., meet the expanded Medi-Cal Program requirements from 1998).
- A 61.59 percent federal matching rate for all non-pregnancy related services for legal immigrant pregnant women residing in the U.S. for less than 5-years, who are enrolled in Medi-Cal.
- A 61.59 percent federal match per the ARRA for legal immigrant children residing in the U.S. for less than 5-years who are enrolled in Medi-Cal and are not part of the CHIP funding stream.

Budget Discussion Issue. Due to timing, this CHIPRA funding is *not* reflected in the February 18-month budget package. The Administration will be reflecting this change in the Governor's May Revision.

However, based on preliminary estimates by the DHCS, a savings of $10.1 million (General Fund) can be achieved from the *additional* receipt of federal funds due to this CHIPRA change. Of this amount, $2 million would be attributable to 2008-09 (assuming an April 1, 2009 date), and $8.1 million would be achieved in 2009-10. Most of this federal funding support will be provided through Title XXI federal funding (i.e., funds used for Healthy Families support), with a smaller amount provided through Title XIX (i.e., funds used for Medi-Cal Program support).

It should be noted that the Administration will need to submit a "State Plan Amendment" (jointly for the MRMIB and DHCS) to the federal CMS in order for California to receive these enhanced federal funds.

Subcommittee Staff Comment and Recommendation. CHIPRA provides the option for States to obtain federal funds for this population as noted. This CHIPRA option would save about $10.1 million in General Fund support in Medi-Cal, as well as about $12.2 million in General Fund support in the Healthy Families Program (as discussed under the MRMIB item).

The Administration will be providing an update to this issue at the May Revision and as such, it is recommended to hold this issue "open" and to have the DHCS respond to questions.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a brief summary of this CHIPRA option and how California can obtain additional federal funds for this population which is already being served.
2. **DHCS**, What is needed for California to obtain these additional federal funds?
3. **DHCS**, Would any state statutory changes be needed within the Medi-Cal Program for this purpose?

3. Federal CHIPRA Changes to Citizenship Documentation

Background—Existing Citizenship Requirements and CHIPRA Changes. The federal Deficit Reduction Act (DRA) of 2005 required states to implement certain citizenship and identity documentation requirements in the Medicaid Program (Medi-Cal). Through state statutory changes and directives from the DHCS, California implemented these "DRA" citizenship and identity requirements in late 2007, with full statewide implementation by July 2008.

The DHCS states that the existing DRA citizenship and identity process costs about $30 million ($15 million General Fund) annually. County eligibility offices for Medi-Cal must process and verify documents received from Medi-Cal clients. For example, clients must provide an original or certified copy of their birth certificate and their driver's license. Copies of documents are not acceptable, and applicants must provide originals.

Effective January 1, 2010, federal CHIPRA provides states with the "option" to adopt a Social Security Number (SSN) verification process. The federal Social Security Administration would validate the name, SSN, and the citizenship status and identify of each SSN submitted by the state and return results to the state. States must submit the data match at least monthly.

CHIPRA establishes a reasonable opportunity period of 90-days for individuals to provide acceptable documentation *if* the state adopts the SSN verification option and does *not* receive verification from the federal Social Security Administration for the individual's SSN. CHIPRA also authorizes full-scope Medi-Cal coverage during this period for those who are otherwise eligible for Medi-Cal (meaning income eligible and the like).

CHIPRA also has a new monthly reporting requirement for states that requires a *three percent error rate* threshold for validation of SSN's. States must maintain this three percent threshold to avoid financial penalties. The financial penalty is the cost of services provided to *ineligible* beneficiaries above the three percent threshold.

However, the three percent error rate and financial penalty will *not* apply to a state if the state has agreed to submit data to the federal Social Security Administration on a "real-time" basis (versus the monthly basis as referenced).

The DHCS states that California currently has a *five percent error rate* for its bi-annual validation of SSN's. They note that this is using an older process for which the federal Social Security Administration did not provide citizenship information for all SSN's submitted by the state.

Budget Discussion Issue. This new CHIPRA option maybe more cost beneficial to the State, and may be more "consumer" friendly than the existing "DRA" citizenship and identity verification process. The Administration should explore this option more fully.

Subcommittee Staff Comment and Recommendation. In discussions with the DHCS, it appears the new CHIPRA option could simplify the Medi-Cal enrollment process over time, in lieu of using the existing "DRA" process.

Using the federal Social Security—either on a monthly basis or in "real time"-- would alleviate the burden currently placed on many Medi-Cal clients, and could be more cost-beneficial to the State overall. Additional documentation for Medi-Cal clients would only be needed for those individuals for whom the federal Social Security Administration cannot validate with an SSN match. These individuals would then have the 90-day window to provide information and they would receive full-scope Medi-Cal during this period.

The DHCS should report back at the May Revision regarding this option.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Could this new CHIPRA option be more consumer friendly for Medi-Cal clients, as well as more cost-beneficial to the state over time? If so, why?
2. **DHCS**, What may be needed to begin implementation of this option in 2009-2010?
3. **DHCS**, the effective date of this option is January 1, 2010, but when does the three percent error rate threshold requirement become effective as well as the financial penalty?

4. Federal CHIPRA—Potential for "Performance Bonus" Payments

Background—Federal CHIRPA and "Performance Bonus" Payments. CHIPRA offers federal fund performance bonus payments for enrollment and retention of children in the Medi-Cal Program. Performance bonus payments will be offered to states for five years (from federal fiscal year 2009 through 2013).

In order to be eligible for these performance bonus payments, a State *must*: **(1)** increase their Medicaid (Medi-Cal) enrollment among low-income children above a "baseline" threshold as defined in CHIPRA; and **(2)** implement at *least five* of eight specified enrollment and retention practices.

With respect to increased enrollment, the performance bonus payment is based on comparing each years "baseline" child enrollment as defined in CHIPRA, with California's actual child average monthly Medi-Cal enrollment during federal fiscal year 2009 and beyond. The calculation takes into consideration a state's growth rate in population for children as well in order to determine performance.

According to the DHCS, the federal performance bonus payments can vary from 15 percent to 62.5 percent of the average per-capita Medi-Cal cost of a child, with the higher percentage provided for the number of children enrolled in excess of 110 percent of the "baseline" threshold.

The eight enrollment and retention practices are listed below. According to the DHCS, California presently meets five of these enrollment and retention practices with the implementation of SB 24 X3 (Alquist), Statutes of 2009. Specifically, California has the first five items shown below.

- 12-month eligibility;
- Elimination of the asset test for children;
- Elimination of in-person interview requirements;
- Use of a joint application;
- Use of presumptive eligibility;
- Use of streamlined renewal;
- Use of a new "Express Lane" option that allows states to apply eligibility determinations made by other public agencies to Medicaid (Medi-Cal);
- Use of premium assistance subsidies.

As such, the amount of federal performance bonus payments California may receive is contingent upon increased enrollment among low-income children as calculated.

Constituency Concerns. The Subcommittee just received a letter from a constituency group questioning whether California indeed meets the joint application requirement (between Healthy Families and Medi-Cal for Children) since the constituency group's interpretation of the requirement is that both programs must also use the same verification process, which is presently not fully the case.

Therefore, they contend that other streamlining measures would be needed, such as implementation of SB 437 (Escutia), Statutes of 2006, or other pending legislation regarding administrative streamlining in order for California to meet the criteria to be eligible for any federal bonus.

Budget Discussion Issue. The federal CHIPRA performance bonus payment is a new concept and it appears that California may be eligible to obtain a federal payment during the 2009-10 state fiscal year. Therefore, the Administration may be coming forward at the May Revision with a calculation regarding receipt of these additional federal funds.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS,** is it likely that California will be eligible for a federal performance bonus payment? If so, what is the potential dollar range of this payment for California based on preliminary information? What would the potential timing of such payment be from the federal government?
2. **DHCS**, What can federal performance bonus payments be used for and are there any restrictions in the use of the funds?
3. **DHCS**, Any other aspects the Subcommittee should be aware of regarding this new federal performance bonus availability?

5. Medi-Cal Eligibility Verification—Trailer Bill, Contract Funds & Staff (See Hand Outs—three pieces)

Budget Discussion Issues. The February budget package provides $250,000 ($125,000 General Fund) for a contract, and funds for one Associate Governmental Program Analyst to conduct verification of assets for Medi-Cal applicants and enrollees whose Medi-Cal eligibility is based on being Aged, Blind, or Disabled (i.e., have these eligibility category aid codes). Trailer bill legislation is also proposed. The intent of this proposal is to comply with federal law changes.

The DHCS states this contract will be with a vendor to provide a secure, web-based means for counties to request asset information from financial institutions to supplement verification for Aged, Blind, or Disabled individuals in order to be compliant with new federal requirements. The vendor would also be required to track the required reporting elements based on the financial institutions responses and generate the reports for the DHCS when needed for submission to the federal CMS. At the request of the Subcommittee, the DHCS has provided a flow-chart to summarize how the this process is to work (See Hand Out).

The DHCS is *proposing sweeping* trailer bill language to require that Medi-Cal applicants and enrollees who are Aged, Blind, or Disabled provide authorization for the State to request from any financial institution any financial record held by the institution with respect to the applicant or enrollee and such other person, as applicable, whenever the State determines the record is needed for making a Medi-Cal eligibility determination.

This trailer bill language *also* requests exemption from provisions of the Public Contract Code and Department of General Services review for the DHCS to conduct its own competitive bid process to hire a contractor quickly (such as by Summer 2009) in lieu of going through the Department of General Services.

The DHCS contends an expedited contract process is necessary in order to show a "good faith" effort to meet the federal timeline contained in House Resolution 2642 of 2008. Specifically, this federal law requires an asset verification program, as specified, by October 1, 2009. The Administration notes that the federal CMS could impose sanctions on California for any delays, such as loss of federal funds.

Background—Federal House Resolution 2642 of 2008 (Hand Out). Title VII, Section 7001 (d) of this federal law adds Section 1940 to the Social Security Act which pertains to Medicaid asset verification through access to information held by financial institutions.

Specifically this federal law does the following:

- Requires States to electronically verify the assets of Medicaid (Medi-Cal) applicants and beneficiaries whose eligibility is based on being Aged, Blind, or Disabled through electronic requests sent to financial institutions, *whenever the State determines that such requests are needed in order to determine or re-determine the individual's eligibility.* California must implement a system by October 1, 2009, or show good faith that we are proceeding towards implementation.

- *Requires States to inform any person who provides authorization (i.e., access to their financial records) of the duration and scope of the authorization.*

- Generally declares that the federal Right to Financial Privacy Act does not apply for these purposes, as noted (See hand out—HR 2642, 2008, page 71, (d)).

- Requires each applicant or recipient whose eligibility is on the basis of being Aged, Blind, or Disabled, and any other person whose assets are required by law to be disclosed to determine the eligibility of that applicant or recipient, to provide authorization for the State to obtain from any financial institution any financial record with respect to the applicant/recipient *whenever the State determines* it is necessary to make the eligibility determination or re-determination.

- Directs that if an applicant or recipient of Medicaid (Medi-Cal) refuses to provide, or revokes, any authorization made by the applicant or recipient for the State to obtain from any financial institution any financial record, the State ***may***, on that basis, determine that the applicant or recipient is ineligible for Medicaid (Medi-Cal).

- Directs that there shall be *no cost* to the applicant or recipient for the State to obtain this information.

- Says that States may select and enter into a contract with a public or private entity meeting criteria and qualifications as the State determines appropriate, consistent with federal law. *Any contractor shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.*

- Requires States to use an approach for verifying an individual's assets in a manner consistent with what the federal Social Security Administration is using.

- Requires States to submit a State Plan amendment to the federal CMS to specify the States' approach on implementing this law.

- Requires States to report certain information as specified to the federal CMS.

Constituency Concerns with Trailer Bill Language. The Subcommittee is in receipt of letters expressing considerable concerns with the trailer bill language. *First*, the language requires an individual to consent to the asset verification process as a condition of Medi-Cal eligibility. This requirement is beyond that which is contained in the federal law.

Second, the language broadly states that asset verification authorization shall be provided "whenever the State determines that the record is needed." No criteria is established or even outlined regarding how and when the authorizations will be required or what standards will be used for these activities. Therefore, implementation by individual counties or eligibility workers will likely be inconsistent and even *possibly* unintentionally discriminatory.

Third, the language broadly states that assets shall also be provided "by any other person whose resources are required by law to be disclosed". This provision most likely violates legal agreements in *Sneede v Kiser* (728, Supp. 607 of 1990) which limits whose assets can be counted towards the Medi-Cal enrollee's eligibility.

Fourth, there are also various important procedural issues which are not clear with the language or the proposal overall. These include the following:

- Will these Aged, Blind and Disabled applicants be delayed enrollment for long periods of time due to the need for the asset verification process? Will all other written documentation be waived if electronic verification of assets is conducted?
- How are county eligibility workers to process and track this information?
- Will "face-to-face" interviews now be necessary due to this proposed change?

Subcommittee Staff Comment and Recommendation. *First*, California will need to provide the federal CMS with a State Plan Amendment to our Medi-Cal Program to meet the requirements of the H.R. 2642. If we do not, it is very likely a loss in federal funds will occur. Therefore, no concerns are raised regarding the $250,000 for the contract or the need for the Associate Governmental Program Analyst.

Second, Subcommittee staff concurs with concerns expressed by constituency groups regarding the proposed trailer bill language. The DHCS proposed trailer bill is broadly written and goes further than federal law in some instances. In addition, it does not even contain appropriate clarity regarding privacy protections or notices to Medi-Cal enrollees explaining the system.

Third, the DHCS is proposing to implement these changes without regulation. The DHCS has a habit of skirting the development of appropriate State regulation by using an "All County Letter" process in which the DHCS provides direction as it sees fit. Often times these letters are modified or portions of them are modified, in lieu of doing State regulations. This process has created concerns with overall administration of the Medi-Cal Program. Therefore, the DHCS needs to include regulations as part of the trailer bill language.

Further, what is most disconcerting is that the Administration has not yet developed the criteria for determining which groups/individuals within the Aged, Blind and Disabled category would undergo electronic verification of assets. According to the DHCS, the federal CMS has indicated there is flexibility to "target" certain populations. Further the DHCS has expressed its desire to obtain constituency group input on criteria for determining who will be subject to this verification.

Therefore, it is recommended to leave the trailer bill language "open" and to direct Subcommittee staff to work with the DHCS and constituency groups to craft a compromise. This language would be brought back to the Subcommittee *prior* to the May Revision for consideration. As such, the DHCS needs to *quickly* proceed with conversations to obtain constituency group input.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a brief overview of this federal issue and the Administration's proposal to address it.
2. **DHCS**, Please provide a quick walk-through of the flow-chart provided to the Subcommittee.
3. **DHCS**, When will the state be meeting with constituency groups on this issue?

6. Update on Medi-Cal Managed Care and Proposed Trailer Bill Legislation

Budget Discussion Issue. The DHCS is proposing trailer bill language to clarify that a County Organized Healthcare System (COHS) can operate under Medi-Cal in more than one county without it being in a contiguous county. Specifically, the proposed trailer bill language modifies Section 14087.9 of Welfare and Institutions Code as follows:

> 14087.9. A combination of counties may contract with the department pursuant to this article for the provision of services ~~on a regional basis~~.

The DHCS states they are requesting this statutory change because Merced County plans to affiliate with a COHS that does not operate in a contiguous county. The DHCS contends that the existing statute is vague and could be interpreted to prohibit expansion of the COHS model of Medi-Cal Managed Care into counties outside of a finite area.

Specifically, Merced County officials have informed the DHCS that they plan to affiliate with Central Coast Alliance for Health, another COHS currently serving Santa Cruz and Monterey counties. As such, the DHCS believes this statutory change is needed.

It should be noted that the Medi-Cal Estimate for 2009-10 reflects an increase of $32.2 million ($16.1 million General Fund) to account for this trailer bill change to enable Merced County to contract with the Central Coast Alliance for Health. This increase assumes a July 1, 2009 implementation date.

This cost is attributable to the fact that Medi-Cal capitation payments will begin immediately, while Fee-For-Service Medi-Cal payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services.

Background—Expansion of Medi-Cal Managed Care in 2005. Through the Budget Act of 2005 and accompanying trailer bill language, Medi-Cal Managed Care was geographically expanded to include 13 new counties.

The original expansion called for implementation using the “Geographic Managed Care” model and expanding existing COHS’s. However, through discussions with local stakeholders and local government, the DHCS has modified its plan accordingly.

The DHCS states that four of the original 13 expansion counties (El Dorado, Imperial, Marin and San Benito) are not ready or suitable for managed care expansion primarily due to concerns about assuring adequate provider networks. Two other counties—Merced and Ventura—pursued federal legislation to allow them to form new COHS (HR 6331 of 2008).

The following Table provides an update on expansion of the Medi-Cal Managed Care Program.

Table: Update on Medi-Cal Managed Care Expansion of 2005

Expansion County	Original Implementation Date	Revised Implementation Date	Managed Care Model
Placer	3/01/07	6/01/09	Geographic Managed Care
Fresno	10/01/07	10/01/10	Conversion to Tri-County Regional Two-Plan with Kings & Madera
Kings	10/01/07	10/01/10	Same as above
Madera	10/01/07	10/01/10	Same as above
Merced	10/01/07	10/01/09	COHS, Joining Central Coast Alliance
Lake	4/01/08	new date unknown	COHS, Joining Partnership Health Plan
Mendocino	4/01/08	new date unknown	COHS, Joining Partnership Health Plan
San Luis Obispo	4/01/08	Completed 3/01/08	COHS, with Santa Barbara Regional Health
Sonoma	4/01/08	10/01/09	COHS, Joining Partnership Health Plan
Ventura	4/01/08	new date unknown	COHS, will become its own

Background—Overview of Medi-Cal Managed Care. The DHCS is the largest purchaser of managed health care services in California with almost 3.5 million enrollees, or about 50 percent of enrollees, in contracting health plans.

The state's Managed Care Program now covers 23 counties through three types of contract models—Two Plan Managed Care, Geographic Managed Care, and County Organized Health Systems (COHS). Twenty health plans have contracts with Medi-Cal within the 23 counties. Some of the plans—like commercial plans—contract with Medi-Cal under more than one model (i.e., commercial plan in Two Plan Model and participate in the Geographic Managed Care model for example).

For people with disabilities, enrollment is mandatory in the County Organized Health Systems, and voluntary in the Two Plan model and Geographic Managed Care model. About 280,000 individuals with disabilities are enrolled in a Medi-Cal Managed Care plan.

Each of these models is briefly described below.

- *Two-Plan Model.* The Two Plan Model was designed in the 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, can voluntarily enroll if they so choose. About 72 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

- *County Organized Healthy Systems (COHS).* Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher costs aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models. About 632,000 Medi-Cal enrollees receive care from these plans. This accounts for about 18

percent of Medi-Cal Managed Care enrollees.

- *Geographic Managed Care Model.* The Geographic Managed Care model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. Sacramento and San Diego counties contract with nine health plans that serve 358,000 Medi-Cal enrollees or about 10 percent of all Medi-Cal managed care enrollees in California.

Subcommittee Staff Comment and Recommendation. *First*, as noted in the Table above, Merced implementation has now moved to an October 1, 2009 implementation date. Therefore, the additional cost associated with the capitation payments will decrease. A more comprehensive update on these payments will be provided in the Governor's May Revision.

Second, the proposed language change appears to be a reasonable accommodation to enable Merced County to contract with Central Coast Alliance for Health.

No issues have been raised regarding the proposed trailer bill language. It is therefore recommended to adopt it as proposed.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a *brief* update on the status of the 2005 expansion of Medi-Cal Managed Care.
2. **DHCS**, Please provide a *brief* description of why the trailer bill language is being requested and its intended affect.

7. Request for Staff in the DHCS Waiver Unit for the Mental Health Services Waiver

Budget Discussion Issues. The DHCS is requesting an increase of $331,000 ($166,000 General Fund) to support three positions to enable the DHCS to respond to the federal CMS audits and to continue making improvements in the coordination and management of the Medi-Cal Mental Health Waiver.

As the lead state agency for Medi-Cal, the DHCS is ultimately responsible for administering California's Medi-Cal Program, including all Waivers which are operated by other state departments, such as the Department of Mental Health.

As noted below, and has been discussed recently in our March 26th hearing, more oversight is needed in order to effectively administer this Waiver. Even with the addition of this proposed staff, the DHCS states that California may face budget deficiencies, overpayments, and interest penalties for late payments to County Mental Health Plans.

In addition, the DHCS contends that the federal CMS *could even cancel* this Medi-Cal Mental Health Waiver due to federal CMS audit concerns.

Background-- Continued Concerns with Fiscal Integrity. This Subcommittee has discussed fiscal integrity issues regarding the operation of state mental health programs for the past four years, including *five reports* prepared by the Office of Statewide Audits and Evaluations (OSAE), Department of Finance.

Further, the Subcommittee's March 26th hearing regarding the Department of Mental Health, noted significant fiscal management issues have continued to be raised regarding the state's administration of the overall Medi-Cal mental health system (including the Early and Periodic Screening and Treatment Program, and Mental Health Managed Care).

There are several aspects to this concern, but first and foremost are fiscal audits by the federal Centers for Medicare and Medical (CMS), *coupled with* the need for continued work to "restructure" the payment process for the state to reimburse counties and other providers within a 30-day period, versus the 90-day to 120-day timeframe that exists today.

The federal CMS has recently released two audits with findings and presently has three more audits that are in process. All of these audits and reviews pertain to concerns regarding lack of fiscal controls, overpayments, and lack of coordination with the Department of Health Care Services regarding the management of reimbursements made under Medicaid (Medi-Cal in California).

Key findings and outcomes from the two released audits (in September 2008 and December 2008) include the following:

- The DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health program expenditures reported to the federal CMS (using form 64) likely to be significantly misstated.

- DMH transferred a total of almost $21 million in federal funds back to the federal CMS as repayment for "excess" federal funds it had claimed incorrectly, due to overpayments in the EPSDT Program (for 2003-04), and claims the DMH made for programs not operated under Medi-Cal (i.e., certain state-only programs and other federal programs).
- The DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices (such as for the EPSDT Program and Mental Health Managed Care Program).
- California's existing reimbursement methods, processes and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes. Therefore, the state must provide the federal CMS with a "State Plan Amendment" by July 1, 2009 that articulates all of these practices.
- By July 1, 2009, California must implement controls to ensure that the process used to count County Realignment Funds (i.e., "certified public expenditures") towards the federal match, meets federal requirements.
- California needs to implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

The three remaining federal CMS audits which are presently underway are described below:

- Audit #3—Financial Management Review. The federal CMS has completed field work at five counties, including San Francisco, Los Angeles, San Diego, Orange, and Sacramento to examine how counties utilize their County Realignment Funds to draw federal matching funds, and other aspects of the reimbursement process. Outcomes from this review are still pending.

- Audit #4—Payment Error Rate Measurement Audit. The federal CMS conducts this audit to identify program vulnerabilities that result in improper payments and to promote efficient Medicaid (Medi-Cal in California) programs. The state is presently working with the federal CMS regarding a "Post Project Review" document and a "Corrective Action Plan"; this information is due to the federal government by April 1, 2009.

- Audit #5—Program Integrity Audit. The federal CMS conducts this audit to determine overall program integrity to policies and procedures, and to learn how states receive and use information about potential fraud and abuse involving Medicaid providers. It is anticipated that the federal CMS will release the results of this audit in 60-days or so.

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements. This Waiver *expires as of June 30, 2009 and must be renewed* with the federal CMS.

Subcommittee Staff Recommendation. *First*, it is recommended to provide the DHCS with the requested positions. However, due to the state's fiscal situation, it is recommended to reduce the Department of Mental Health's state support item by a like amount--$166,000 (General Fund) to fund the DHCS positions. The DMH can allocate this reduction as determined by the Director of the Department. For example, the reduction can be achieved through operating expense reductions, salary savings, contract reductions or other approaches, and can be spread across all administrative areas of the Department (such as the state hospitals section or the executive branch).

Second, it is recommended to adopt *placeholder* trailer bill language to require the DHCS to provide the results of *any* federal audits, including federal CMS or any other federal agency, regarding the Medi-Cal Program to the fiscal and policy committees of the Legislature.

Third, it is recommended to adopt *placeholder* trailer bill legislation to require the California Health and Human Services Agency (CHHS Agency) to provide the policy and fiscal committees of the Legislature with a comprehensive "Action Plan" as to what key changes are necessary to improve the operations of these services between these two departments, as well as a timeframe for when key milestones are to be completed, including all claims processing procedures and work products (such as the various recommendations contained in the OSAE Reports and federal CMS audits, as well as the Short-Doyle II system).

It should be noted that placeholder trailer bill language is recommended in order to draft a compromise which is workable for the Administration.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a *brief* summary of the Finance Letter request and why these positions are necessary.
2. **DHCS**, Please provide a brief update as to the state's submittal of the Waiver renewal for Mental Health Services since the existing Waiver expires as of June 30, 2009. Is the state's Waiver at risk due to the federal CMS audits as previously noted by the DHCS?

8. Trailer Bill Language & Staff for Mental Health Services Supplemental Payments Program (Hand Out)

Budget Discussion Issues. The Subcommittee is in receipt of a Spring Finance Letter to develop and implement a Mental Health Services Supplemental Payment Program to be administered by the Department of Health Care Services (DHCS).

The DHCS is requesting an increase of $101,000 ($50,000 in reimbursements from Counties and $50,000 in federal funds) to support an Associate Governmental Program Analyst, and comprehensive trailer bill language to establish the program. The position would be used to develop and administer the program, including the establishment of claims processing and payment protocols. No issues have been raised regarding the need for the position.

This new Mental Health Services Supplemental Payment Program would be modeled after other existing DHCS "supplemental payment" programs. Specifically, it would authorize County Mental Health Plans (County MHPs) to submit "certified public expenditures" (CPEs) to the DHCS for the purpose of claiming federal financial participation to reimburse County MHPs for the costs of mental health services provided to Medi-Cal enrollees that *exceed their current payment levels*.

The supplemental payment would consist of the difference between the current Fee-For-Service rate being paid for these services and the actual costs to the counties to provide the mental health services. It should be noted that these supplemental payments can also be used to reimburse providers of Medi-Cal mental health services other than counties; however, it is the county CPE that must be used to claim the federal reimbursement.

Participation in the program by counties would be completely voluntary. The DHCS would invite counties to participate on an annual basis. Generally, it would be large counties who would most likely choose to participate in order to claim the additional federal funds since they are more likely to be incurring these costs.

It should be noted that the DHCS has already submitted a *draft* State Plan Amendment to the federal CMS in order to implement the program retroactively to January 1, 2009. This provides California with a longer period in which to claim federal reimbursement for these uncompensated county expenditures. This new program would be eligible to obtain the federal ARRA level of federal FMAP at 61.59 percent.

Based on preliminary information as contained in the draft State Plan Amendment, it is anticipated that $27.7 million (federal funds) can be obtained for 2008-09 and $55.4 million can be obtained for 2009-10. This increased federal funding would be very beneficial to local entities providing mental health services.

Constituency Group Concerns. Several constituency groups representing the County Mental Health Directors Association and community-based providers have expressed concerns regarding the DHCS language and the need to be involved in the development of the new program. Discussions have commenced to hopefully achieve a compromise.

Subcommittee Staff Comment and Recommendation. The implementation of a Mental Health Services Supplemental Payment Program makes sense for California. It would enable the Medi-Cal Program to obtain additional federal funds for mental health services through the use of the CPE process.

Subcommittee staff believes a consensus could be reached where trailer bill language could be crafted which would enable certain providers, under specified circumstances, to benefit from these supplemental payments as well as County MHPs. It is recommended to direct interested parties to work with the Administration and Subcommittee staff to develop a compromise.

In addition, the DHCS and DMH need to ensure that full coordination between these two departments will occur so there are no federal CMS audit concerns.

Questions. The Subcommittee has requested the DHCS and DMH to respond to the following questions:

1. **DHCS**, Please provide a *brief* summary of the proposal, including the proposed trailer bill language. Specifically, how would the program operate?
2. **DHCS and DMH**, How will coordination occur across the two departments to ensure appropriate development and implementation of this program?

9. Trailer Bill Language to Establish Maximum Allowable Ingredient Costs for Generic Drugs Dispensed by Pharmacists (Hand Out)

Budget Issues Discussion. The February budget package assumes savings of $2 million ($1 million General Fund) for 2009-10 by implementing trailer bill language to establish a *new* Maximum Allowable Ingredient Cost (MAIC) within the Medi-Cal Program. Annual savings are estimated to be $24 million ($12 million General Fund).

The savings assumes a June 1, 2010 implementation date by the DHCS since system changes and other administrative actions require time to implement. Trailer bill language needs to be enacted before this savings can be achieved.

The Administration's proposed trailer bill language would allow the Medi-Cal Program to set MAIC using *either* (1) the Average Manufacturer Price (AMP); (2) the Wholesaler Acquisition Cost (WAC); *or* (3) to contract with a vendor to establish MAIC prices.

The DHCS states that changes in the MAIC calculation are necessary because the existing Medi-Cal MAIC depends on the use of AMP as reported by the federal CMS to states. However, due to a federal court injunction and federal law changes, the federal CMS cannot readily provide this information to states.

The DHCS contends that the benefits to this trailer bill change are as follows:

- Increases the use of generic drugs in the Medi-Cal Program.
- Establishes a maximum reimbursement process that has been inactive in the Medi-Cal Program.
- Will maintain or increase savings in Medi-Cal.

Establishment of the new MAIC will reduce payment for many generic drugs. This will affect the reimbursement amount received by some pharmacies since the DHCS is not proposing any adjustments to the dispensing fee component of the rate. However, this proposal will also increase the use of some generic drugs. The DHCS contends that a shift away from some brand name drugs to generics with the new MAIC can be expected to financially benefit some pharmacies.

Overall, the extent of savings will depend on the differences between the current reimbursement and the new MAIC, and in those situations where the brand name drug is preferred, the difference between the net cost (cost after rebates) of the brand name drug and the net cost of the generic drugs, plus the drug utilization patterns after the new MAIC is established.

Background—Pharmacy Reimbursement Under Medi-Cal. Pharmacy reimbursement consists of two components—a drug ingredient cost and a dispensing fee. With respect to the drug ingredient cost component, Medi-Cal presently calculates this cost at the "Average Wholesale Price" minus 17 percent. The dispensing fee component is $7.25 per prescription except for long-term care pharmacies which receive $8.00 per prescription.

Generally, the drug ingredient cost constitutes about 85 percent of the payment per prescription to a Pharmacy.

The rate reduction for Pharmacy reimbursement enacted in AB 1183, Statutes of 2008, is presently not in affect due to a court injunction (a 10 percent reduction effective July 1, 2008 to February 2009 and then a 5 percent reduction effective March 1, 2009).

Background—Summary of Previous Efforts Regarding MAIC. MAIC is an upper payment limit that creates a maximum reimbursement for generically equivalent drugs. MAIC is only used by Medi-Cal.

Originally, MAIC was defined in regulations as being equal to Average Wholesale Price (AWP) minus 5 percent price of a reference generic drug (typically the drug with the lowest AWP) with the provision that the Drug Manufacturer of the generic drug would be able to provide enough drug products to meet Medi-Cal's needs.

Unfortunately, this regulation did not mandate for Drug Manufacturers to supply this information. Therefore, the DHCS was generally unable to establish new MAIC prices. As a result a "new" MAIC definition was established in state statute in 2004.

This MAIC definition in 2004 was to be based on the Wholesale Selling Price (WSP). WSP was to be the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor. Instead of using a single product, this methodology would use all generic equivalent products to calculate a weighted average that would be MAIC.

This 2004 definition of MAIC was halted when Congress declared they would move to an Average Manufacturer's Price (AMP) based on Federal Upper Limits (FUL). In 2007 this definition was changed to make MAIC equal to the mean of the AMP of drugs generically equivalent to the particular innovator (i.e., brand drug) plus a percent markup determined by the DHCS to be necessary for MAIC to represent the average purchase price paid by retail pharmacies in California.

The federal CMS issued regulations (to be effective October 1, 2007) regarding this calculation of FUL and AMP prices. However, the National Association of Chain Drug Stores and the National Community Pharmacists Association filed a complaint for injunctive relief contending that implementation was unlawful and would cause harm. Federal court issued a temporary injunction barring federal CMS implementation. Further, House Resolution 6331 delays implementation of FUL prices and AMP reporting until October 1, 2009.

Since the MAIC for Medi-Cal relies on the use of AMP reported by the federal CMS to states, it has been impacted by both the federal court injunction as well as the delay enacted in H.R. 6331.

Background—Description of Key Terminology. The following key definitions and terminology are provided only as a reference for discussion purposes.

- Average Manufacturer Price (AMP). This is the average price paid to the Drug Manufacturer for the drug in the United States by wholesalers for drugs distributed to retail pharmacies.
- Average Wholesale Price (AWP). Historically, the AWP has been the generally accepted drug payment benchmark for many payers because it was readily available. The primary sources of AWP are the drug data companies—most notably "First Data Bank". The Medi-Cal Program currently uses First Data Bank as the source of AWP and other drug data reported by the Drug Manufacturers. Drug companies updated their database files continuously. Many pharmacies and third party payers, including Medi-Cal, obtain updated pricing on a weekly basis.
- Wholesaler Acquisition Cost (WAC). The WAC is generally a list price set by Drug Manufacturers for each of their products. WAC is supposed to represent what a wholesaler pays for a drug. However, WAC does not reflect discounts or price concessions offered by Drug Manufacturers. Drug Manufacturers report WAC prices directly to First Data Bank.
- Federal Upper Limit. Prior to certain federal law changes, the Federal Upper Limit (FUL) was defined as the reimbursement limit for each multiple source drug for which the federal Food and Drug Administration has *rated three or more* products therapeutically equivalent. Generally, drug products are considered pharmaceutical equivalents if they contain the same active ingredients are of the same dosage form, route of administration and are identical in strength or concentration.

  Federal law changes (Deficit Reduction Act of 2005) decreased the number of equivalent drugs from three to two and changed the reimbursement calculation. As noted above, these federal changes have not been implemented.
- Non-Innovator Multiple Source Drug. These drugs are often referred to as "generic drugs" and are *therapeutically equivalent* to Innovator Multiple Source Drugs which are referred to as "brand drugs".

Constituency Groups. The Subcommittee is in receipt of letters expressing some concerns with the crafting of the trailer bill language and have offered suggested changes to the DHCS. Some of the concerns include the following:

- The proposed trailer bill language needs to be more explicit in determining how the new MAIC will be set.
- The new MAIC for Medi-Cal should only be determined for those generic drugs that do not have a Federal Upper Limit established by the federal CMS.
- The new MAIC should only be determined for products that have at least three "A-rated" sources of every strength and are widely available for purchase in California pharmacies.

Subcommittee Staff Comment and Recommendation. It is makes fiscal sense for the DHCS to propose a new MAIC. However trailer bill language needs to be modified to address some constituency concerns and to make the mechanics of statue clearer.

Therefore, it is recommended to leave the trailer bill language "open" and to direct the DHCS to provide revised trailer bill language to the Subcommittee *prior* to the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. **DHCS**, Please provide a *brief* summary of the proposed trailer bill language and the purpose of it.
2. **DHCS**, What are the specific benefits to the Medi-Cal Program for enacting this language?